

# A Long-Term Care Plan for North Carolina

## Synopsis of the North Carolina Institute of Medicine Final Report

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### Significant Changes are Needed to Improve North Carolina's Long-Term Care System

No set of issues related to the health of North Carolinians is more important or more complicated than those dealing with long-term care for the state's older adults and people with disabilities and their families. Sixty percent of persons beyond the age of 65 will need long-term care services either in-home or in a residential setting sometime in their lives, as will many younger people with disabilities. The rapidly growing aging population will place increasing demand on the state's ability to meet the long-term care needs of its citizens.

In 1999, the General Assembly directed the NC Department of Health and Human Services (DHHS) to develop a long-term care system that provides a continuum of care for older adults, persons with disabilities, and their families.<sup>1</sup> The Secretary asked the North Carolina Institute of Medicine (NC IOM) to establish a Task Force to assist the Department in this effort.<sup>2</sup>

### North Carolina's Long-Term Care Policy

Ideally, long-term care services would be provided by home and community-based programs or families on behalf of their loved ones. These services should enable people to live as independently as possible without casting them into poverty. Without adequate private long-term care insurance or public funding, some individuals in need of long-term care

services are faced with three options: (1) find a family member to provide unpaid care; (2) pay a caregiver out-of-pocket; or (3) enter a long-term care facility where, as they more quickly use up their resources to pay for institutional care, they are more likely to qualify for public subsidies. This raises questions of the availability of services and financing needed for people to live independently without institutionalization.

The state's long-term care policy should be to support older adults and people with disabilities and their families in choosing their own living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care in the least restrictive setting. The state's policies and program activities should strengthen the capacity of families to serve as caregivers; however, people in need of additional long-

term care services should have access to certain core services across the state. North Carolina's long-term care system should be accessible and understandable for both public and private pay consumers, and uniform for all.

The Task Force identified 10 significant challenges facing the state in meeting these overriding goals:

1. The state's current long-term care system is fragmented at both the state and local levels. The multiplicity of governmental agencies and service providers makes it difficult for consumers to know where to turn for information or assistance.
2. Consumers are often subjected to multiple assessments across agencies. Because there is little or no sharing of client assessment information across different agencies,

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care coordination is more difficult.

3. The availability of core long-term care services varies widely across the state.
4. North Carolina is in the midst of a long-term care workforce crisis. Efforts to design a long-term care system that ensures availability of services and high-quality care are somewhat meaningless without a supply of trained professional and paraprofessional staff—including nurse aides, nurses, doctors, and allied health professionals.
5. Everyone agrees that the state should strive to provide “high quality” long-term care services, but there is no consensus among different stakeholders about how to define or measure “quality.”
6. Past efforts at ensuring quality have been largely punitive, focusing on imposing penalties and correcting deficiencies among the few “bad” facilities, rather than trying to raise the level of quality among all facilities.
7. Many families will need some type of assistance to pay for long-term care services. Yet Medicaid, the major financing source for long-term care services, has a significant institutional bias. It is easier for people to qualify for assistance if they enter an institution than if they remain at home. Some other public funding sources focus on home and community-based services, but their funding is more limited.
8. Private long-term care insurance can offer consumers a choice of providers, help consumers preserve assets, and offer additional long-term care options. Yet private long-term care insurance is not a viable option for everyone, particularly those with low incomes or significant health problems. The optimal time to purchase long-term care insurance is when a person is younger, as insurance policies are typically more affordable. Waiting until a person ages may make private long-term care insurance unaffordable, or otherwise difficult to purchase.
9. Although local communities have played a leadership role in the efforts to reform the long-term care system, some communities will need assistance in developing the infrastructure needed to bring their programs into line with new state requirements.
10. The state lacks an adequate data system to conduct long-term care policy analysis. For example, the state lacks data about the functional or health status of people using different types of long-term care services and is currently unable to monitor changes in functional or health status as individuals move through the long-term care system (to monitor outcomes).<sup>3</sup> In addition, the state lacks basic information about the overall need for long-term care services. This information needs to be collected at the state level but shared with individual communities to support local planning efforts.

## Recommendations

*Infrastructure:* Early in its deliberations, the Task Force recognized the fragmentation that exists at the state level among the different agencies charged with delivering, financing, or regulating long-term care. Thus, one of the Task Force’s top recommendations was for a more cohesive process to establish state-level long-term care policies and programs. The Task Force recommended the creation of a Cabinet for Long-Term Care within the Department of Health and Human Services, comprising all Division Directors charged with financing, regulating, or providing long-term care services. In addition, the Secretary of the Department of Health and Human Services should create a new Office of Long-Term Care to staff the Cabinet, collect and analyze long-term care data, and develop comprehensive, coordinated long-term care policies. The creation of the new Office of Long-Term Care within the DHHS, and the new Cabinet for Long-Term Care, will help reduce the likelihood of overlapping and sometimes conflicting agendas among Divisions of DHHS.

As a corollary to the Department’s reorganization, comprehensive long-term care planning should be encouraged at the local level. The North Carolina General Assembly should encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level. The Department of Health and Human Services should support these efforts by providing technical assistance and county-level data to assist the communities. In addition, the General Assembly should provide one-time “transition support” to enable counties to implement the recommendations of the Task Force, and additional “capacity building” funds to help small rural counties develop the infrastructure and capacity necessary to implement statewide system changes.

The Task Force also recommended the creation of a “uniform” portal of entry that would improve the process through which citizens could obtain needed long-term care services. The uniform portal of entry would ensure that multiple agencies serving clients use the same screening and assessment tools, and have information about all the available long-term care resources in their communities. To make this system work, the Task Force recommended that the state begin using uniform screening, level of service assessment and care planning instruments; and that the state identify or help develop a computerized information and assistance system that can be used statewide.

*Quality:* There is a need for a continuing dialogue about the standards of quality for long-term care services in our state. A start in this direction has been taken through the work of the Task Force, but this is an ongoing agenda the Task Force felt best passed on to the new Office of Long-Term Care, with active participation by the long-term care

industry, consumer advocacy groups, regulators, and other interested stakeholders. Much is already going on in this area, but the Task Force maintained that an emphasis on “quality improvement” would greatly enhance current efforts. As a beginning, the Office of Long-Term Care should explore methods to improve and reward quality and not limit actions solely to imposing penalties for deficiencies. Similarly, the Department should develop a Quality Improvement Consultation program to assist providers in the development of quality improvement plans for each facility and program offering long-term care services. A partnership arrangement with Medical Review of North Carolina and the state’s public and private universities in this regard was also recommended.

**Workforce:** One of the major challenges facing the state is ensuring an adequate supply of trained professional and paraprofessional staff. With regard to workforce issues in long-term care, the major “crisis” is the current shortage of paraprofessional personnel in these facilities and programs. However, there are also issues related to the preparation of adequate numbers of physicians, dentists, nurses, and other health professionals with the skills and the commitment to work in long-term care. The Task Force recommended that the General Assembly increase appropriations for Medicaid funded in-home and adult care home Personal Care Services (PCS), and nursing home care by increasing the personal care service hourly rate and nursing home daily rate for direct care. This enhancement would be used for wages, benefits, and/or payment of shift differentials (e.g., nights/weekends). Providers would be required to submit additional cost data to ensure that these funds are used for their intended purpose.

In addition to wage enhancements, the Task Force recommended that the General Assembly appropriate funds to develop a continuing education and paraprofessional development initiative, as well as a career ladder for long-term care paraprofessionals. To support these efforts, additional data collection and analysis is needed—for example, to examine the turnover and retention rates, wages and benefits of nurse aides. The state should explore ways to establish a group health insurance purchasing arrangement for long-term care staff; and the General Assembly should establish a Legislative Study Commission to examine long-term care workforce shortages among paraprofessionals and other professionals serving older adults and people with disabilities.

Current efforts made by the long-term care industry to address the long-term care paraprofessional recruitment and retention issues should be applauded and further encouraged. The Task Force recognized that both the state and private industry have a role in addressing the current workforce shortages. Long-term care provider associations should develop plans to improve the recruitment and retention rates among paraprofessionals and professionals in the long-term

care industry. The plans may include mechanisms to improve job satisfaction, increase pay, develop career paths or improve working conditions.

#### *Expanding Access/Financing Long-Term Care Services:*

One of the first steps the state should take in expanding publicly-financed long-term care services is to remove the current institutional bias in these programs. It is currently easier for older adults or people with disabilities to qualify for publicly-financed long-term care services in a nursing home or adult care home than it is to receive services at home. Two promising means of reducing the current institutional bias would be to increase Medicaid income limits for the medically needy to 100% of federal poverty guidelines, and to expand the number of people served by the Medicaid Community Alternative Programs, which serve children and adults with disabilities. Both approaches would enable people to receive long-term care services while living either at home or in a community setting. In addition, the state should explore ways to support family caregivers, thereby reducing the risk for needing formal, publicly-financed services.

The Task Force recognized the state’s strong interest in maximizing the use of federal Medicaid dollars to finance long-term care services, as the federal government pays approximately 62% of all Medicaid service costs. As such, the Task Force recommended that the state explore ways to use existing resources as the state’s match in further Medicaid expansions. Another idea, successfully used in other states, is to ensure that Medicare pays for covered long-term care services for Medicare-eligible individuals.

In addition, the state should launch an outreach effort targeted at “baby-boomers”, to explain different long-term care financing and payment options. The outreach effort should include information on what Medicare covers, what Medicaid covers, what individuals must pay on their own, and what private long-term care insurance can cover.

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#### Notes

- 1 Sec. 11.7A of Chapter 237 of the Session Law 1999-237, as amended by Sec. 11b of the Session Law 2000-67.
- 2 The NC IOM Task Force was chaired by Robert A. Ingram, then Chairman of Glaxo-Wellcome, and the Honorable H. David Bruton, MD. The full Task Force included 49 members, including members of the NC General Assembly, representatives of county commissioners, local governments, long-term care providers and industry associations, consumer advocacy groups and businesses. The Task Force held 11 day-long meetings beginning November 1999 and ending December 2000. The final report was released in January 2001.
- 3 This information is available for nursing homes because the federal government mandates the collection of standardized assessment data across all nursing homes.